Clear Lake Specialties

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of Clear Lake Specialties notice of privacy practices.

Initial-----

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process this claim.

Initial-----

NO SHOWS AND CANCELLATION POLICY:

I understand I must call at least 48 hours in advance to cancel my appointment. There will be a $25 charge for no shows and cancellations that occur less than 48 hours before my scheduled appointment.

Initial-----

Non Medicare Patients:

By signing this notice I agree to take financial responsibility for the cost of the services and supplies performed, used or given, if your insurance company denies coverage.

Initial-----

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I also request payment of insurance Directly to CLS or its subsidiary.

I understand that if **Clear Lake Specialties, PA** or any of its subsidiaries is not paid in full by from my insurance or got denied then I will be responsible for the remaining balance due. I can request a complete copy of this Assignment of Benefits by asking the clinic staff or viewing online at:

https://www.clearlake –specialties.com/insurance-billing-assignment-of-benefits/

Initial-----

_____ _____

Print Name of Patient Date of Birth

_____ _____

Patient Signature Date

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/ OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I the undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my authorized representative, Clear Lake Specialties, PA or any of its subsidiaries including but not limited to ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/ OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE I the undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my authorized representative, Clear Lake Specialties, PA or any of its subsidiaries including but not limited to: Bay Area Foot and Ankle Specialist pa, Clear Lake Cardiology PLLC, Clear Lake Oncology PLLC, Clear Lake Primary Care PLLC, Clear Lake Podiatry PLLC, Clear Lake Wound Care PLLC, Endocrinology Clinic at Clear Lake Specialties, S&S Foot Specialists PA, Infectious Diseases Clinic at Clear Lake Specialties PLLC, Kidney Hypertension Transplant Clinic of Clear Lake PLL, Mosaic Clinic LLC, Neurology Clinic at Clear Lake Specialties PLLC, South Texas Foot Specialist PA, and Webster Rehabilitation Specialists LLC. (collectively, the "Group") the right to pursue payment for benefits, and take any and all necessary steps, including pursing administrative appeals and remedies, filing suit and all causes of action wholly in my stand for benefit payment of all medical benefits to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, Clear Lake Specialties, PA and/or the Provider's subsidiaries including but not limited to the group, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate. I hereby authorize provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator). I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for

all services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider.
I irrevocably hereby designate, authorize and appoint the Provider, Clear Lake Specialties, PA, its subsidiaries, including but not limited to the group, its attorneys as my true and lawful attorney-in-fact to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; to make any request; to present or to produce evidence; to file and obtain any claim, appeal or external review information; to receive any notice in connection with my claim, appeal or external review; wholly in my stead. (3) To file and participate in any administrative or judicial review process; obtain information or submit evidence regarding the claim to the same extent as me; and make statements about facts or law. (4) to act as my authorized representative in connection with my request for an external review by the HHS Federal External Review Process. I authorize this individual to make any request; to present or to produce evidence; to obtain external review information; and to receive any notice in connection with my external review, wholly in my place. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below; (5) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a); (6) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (7) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (8) allow a photocopy of my signature to be used to process insurance claims. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my governing Health and Welfare Plan or policy to include all benefits entitled for all services rendered and/or ordered by my treating physician. This power of attorney will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. This order will remain in effect until revoked by me in writing. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment.

, (collectively, the "Group") the right to pursue payment for benefits, and take any and all necessary steps, including pursing administrative appeals and remedies, filing suit and all causes of action wholly in my stand for benefit payment of all medical benefits to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, Clear Lake Specialties, PA and/or the Provider's subsidiaries including but not limited to the group, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate. I hereby authorize provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator). I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for all services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I irrevocably hereby designate, authorize and appoint the Provider, Clear Lake Specialties, PA, its subsidiaries, including but not limited to the group, its attorneys as my true and lawful attorney-in-fact to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; to make any request; to present or to produce evidence; to file and obtain any claim, appeal or external review information; to receive any notice in connection with my claim, appeal or external review; wholly in my stead. (3) To file and participate in any administrative or judicial review process; obtain information or submit evidence regarding the claim to the same extent as me; and make statements about facts or law. (4) to act as my authorized representative in connection with my request for an external review by the HHS Federal External Review Process. I authorize this individual to make any request; to present or to produce evidence; to obtain external review information; and to receive any notice in connection with my external review, wholly in my place. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below; (5) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 §

U.S.C. 1132(a); (6) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (7) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (8) allow a photocopy of my signature to be used to process insurance claims. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my governing Health and Welfare Plan or policy to include all benefits entitled for all services rendered and/or ordered by my treating physician. This power of attorney will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. This order will remain in effect until revoked by me in writing. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment.